NEW MEDI-CAL ADMINISTRATIVE ACTIVITIES (MAA)
SUMMMARY for REVISED INVOICE

Local Governmental Agency

Program/Department:

Contract Number:

Claiming Unit:

Period of Service:

Invoice Number:

COST CATEGORIES

Line 1	Total Amount to be Reimbursed at 50% (Detail invoice-line CG)	$ 0
Line 2	Total Amount to be Reimbursed at 75% (Detail invoice-line CH)	$ 0
Line 3	TOTAL to be Reimbursed by Federal Government (Detail invoice-line CI)	$ 0
Line 4	Amount Previously Paid (ENTER AS A POSITIVE NUMBER)	$ (0)
Line 5	TOTAL to be Reimbursed by Federal Government	$ 0
Line 6	Adjustment to Total Amount to be Reimbursed at 50%	$
Line 7	Adjustment to Total Amount to be Reimbursed at 75%	$
Line 8	TOTAL to be Reimbursed by Federal Government	$ 0

I certify under penalty of perjury that the information provided on this invoice is true and correct, based on actual expenditures incurred for the period claimed, and that the funds/contributions expended, as necessary for federal matching funds pursuant to the requirement of 42 CFR 433.51, allowable administrative activities and that these claimed expenditures have not previously been nor shall not subsequently be used for federal match in this or any other program. I have notice that this information is to be used for filing of a claim with the Federal government for Federal funds and that knowing misrepresentation constitutes violation of the Federal False Claims Act.

Typed Name of Signer

Signature

Title

Date

Department of Health Services
Administrative Claiming Operations Unit
714 "P" Street, Room 1640
Sacramento, CA 95814

For DHS Program use only

I certify that this claim and any adjustment(s) are in all respects true, correct, supportable by available documentation, and in compliance with all terms/conditions, laws and regulations governing its payment. The final adjusted approved amount for this invoice is $_____.

Approved by: _____

Date _____

Print Name:_____

Print Title:_____